#### PRINTED: 05/21/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICA SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 49G018 B. WING 05/06/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **POST OFFICE BOX 621 BAXTER HOUSE** KEEN MOUNTAIN, VA 24624 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE OATE TAG DEFICIENCY) 5)28/15 W 000 INITIAL COMMENTS W 000 An unannounced annual Medicaid ICF/ID recertification survey was conducted 05/05/15 through 05/06/15. The facility was not in compliance with 42 CFR Part 483 Requirements

## for Intermediate Care Facilities for the Intellectually Disabled. The Life Safety Code survey report will follow.

The census in this 12 certified bed facility was 9 Individuals at the time of survey. The survey sample consisted of 4 current Individual reviews (Individuals #1 through #4).

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

> Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by: Based on observation, staff interview, and clinical record review the QIDP (qualified intellectual disabilities professional) failed to ensure the nutritional management program was consistently followed for 2 of 4 Individuals. Individuals #3 and #4.

The findings included.

1. For Individual #3, the QIDP failed to ensure the Individuals goal to "Improve eating skills" was consistently implemented by the direct care staff.

Individual #3 was admitted to the facility 12/04/90. Diagnoses included but were not limited to: profound intellectual disabilities, intermittent

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W 159

A Staff meeting was immediately scheduled and Completed on Stills which included all amoup home staff, During this staff meeting the impartance of following each individual's meal time Plan was stressed. Signature pages were also placed with each individuals meal time Plan onthis date. All staft persons were informed of the signature pages and the fact they must immediately read and sign each meal time Flow. In add that all staff persons are required to read and sign every meal time plan every three months. The on 5/11/15 and observed to ensure Staff was implementing all

(X6) OATE

Facility Manager Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be occurred from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

PRINTED: 05/21/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDIC SERVICES		<u> </u>	OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUJLI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49G018	B. WING	)	05/06/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	
BAXTER	HOUSE			POST OFFICE BOX 621	
D/O(TEX				KEEN MOUNTAIN, VA 24624	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE COMPLETION EAPPROPRIATE DATE
W 159	constipation.  Individual #3's recordeating skills." The leading skills." The Procedur "Pour 1" (inch) of slow his rate of dring of liquids places him aspiration"  On 05/06/15 beginn a.m. the surveyor of breakfast. Individual meal by RT (resider #3 was observed by coffee cup and take Individual #3 to slow again observed by the coffee from his coffee measured and drink glass without it bein	insomnia, and history of  rd included the goal "Improve esson plan was to be rs per week2 times daily. 00-5:30 PM-Monday-Friday rday-Sunday 9:00 AM-9:30 re for liquids read as follows liquid in a glass at a time to king down. Rapid swallowing rh at a high risk for  ling at approximately 7:00 beserved Individual #3 eating I #3 was assisted with this ratial technician) #1. Individual r the surveyor to pick up his ratial technician) #1. Individual r the surveyor drink RT #1 asked r down. Individual #3 was he surveyor drinking his ee cup without it being ting his milk from a large g measured. At no time t meal was the staff observed	W	meal time plans   Correctly. The OD Continue to require each individuals Plan   diet to ensure are implementing ( The OIDP will person to the oIDP will person to the original attention to the anager, stating findings after e In addition, RT+ a written warn 5   25   15 for failu an individuals me plan,	EDP will  early monitor  meal time  pre start  correctly.  exocide  the facility  their  each visit.  t received  ing on  re to follow
!	Individual #3 tolerated the liquids without difficulty.			RECEIVI	ED
	On 05/06/15 at appr	oximately 7:30 a.m. the		JUN 0 1 201	
:		d RT #1. RT #1 verbalized to			· · · · · · · · · · · · · · · · · · ·
	the surveyor that sh	e usually poured a small		VDH/OL	G
	amount of liquids intacknowledged that	to another cup but she did not do so this am.	-		_
!	The senior team lea	der was notified of the above			;

on 05/06/15 at approximately 8:38 a.m. and the facility manager was notified on 05/06/15 at

DEPART	TMENT OF HEALTH	AND HUMAN SERVICES		, · ·	PRINTED: 05/2° FORM APPR	
CENTE	RS FOR MEDICARE	& MEDIC SERVICES		<u> </u>	OMB NO. 0938	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURV COMPLETED	/EY
		49G018	B. WING_		05/06/20	15
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		<u></u>
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				A staff meeting was	simorational	1981
W 159	Continued From pa	ge 2	W 15	9 Scheduled and com	Sleted on	
	approximately 8:45	a.m.		5/7/15, During this	staff	
	No further informati			meeting, the impor	tance of	
		on regarding this issue was reyor prior to the exit		Following each indi	sideal's	
	conference.	oyor prior to the ext		meal plan was st		
				hazards of not do	rectly	
		the QIDP failed to ensure the		tollowing meal plan	rs were	
	consistently followe	inely chopped foods" was		also discussed. À s	taff involved	
	consistently rollowe	u.		in this incident rea	reived a	
	Individual #4 was admitted to the facility 06/11/13.			written warning	on 5 120115.	
	Diagnoses included	, but were not limited to:	•	on 6/1/15 the day 5		
		al disabilities, intermittent	:	Program will be in	nakmentina	
	explosive disorder, hypothyroidism.	seizure disorder, and		a new meal time of	poch 1. <7	
	Trypotityroldistit.			System. This check	11-11-11	
	The Individuals diet	was documented on the face		will contain each	CI 24 2AZEM	
		pped foods with thickened		dictary needs and	1.0101GPG12	
!		neet had been updated	! !	and require stars	is tole	
	03/17/15.	:		on a daily basis	The day	
!	The 90 day renewal	of orders, signed by the		5- Aport will con-	ince to	
		15, included the diet "Regular		Closely monitor n	real times	
	calorie, Finely chopp	ped with thickened liquids."	1	to ensure meal pl	ens are	
	Individual #4to recor			being correctly fo	llowed	
i	Individual #4's record included the goal "To maintain desired weight for height" The lesson plan included the following steps "1. Provide			3 - 110-1103 10	west.	
		as toleratedfinely chopped				
	Food diet with thickened liquids. 2. Encourage			De promon		
		mall bites to prevent choking.		RECEI	VED	
	5. Direct care stall v	vill provide diet as ordered"			•	
i	The annual nutrition	assessment was completed		JUN 0:1 ;	<b>2015</b>	
:		ent diet is Regular calorie		VDH/O	LC	

Page 12 of 19 of the ISP (individual support plan) read in part "DSP (direct support professional)

	ENT OF HEALTH FOR MEDICARE	AND HUMAN SERVICES  & MEDICA SERVICES			(	FC	FED: 05/21/2015 DRM APPROVED NO. 0938-0391	
STATEMENT OF AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN		TRUCTION		DATE SURVEY COMPLETED	
		49G018	B. WING		<del></del>		05/06/2015	
NAME OF PROVIDER OR SUPPLIER  BAXTER HOUSE				POST OF	EET ADDRESS, CITY, STATE, ZIP CODE T OFFICE BOX 621 N MOUNTAIN, VA 24624		1 10.10.2010	
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W 450 0					-		5/28/15	
	ontinued From pa	ge 3 omitted) food is finely	W 15	9				
	•	n not having any teeth)"						
0	n 05/05/15 beginn	ing at approximately 11:15						
		rrived at the day support						
þr	ogram mar was a	ttended by Individual #4.						
be #4 Sa CC	eginning at approx I was served a lur andwich that had b ocktail, salad, and	ved the Individual eating lunch imately 12:30 p.m. Individual ach that consisted of a been cut in four parts, fruit thickened liquids. Individual pick up his sandwich and mself.					:	
TI	ne Resident tolera	ted the diet without difficulty.					į	
	ter this observation dividuals record.	n the surveyor reviewed the	:				:	
, SL	rveyor interviewe	roximately 3:15 p.m. the d (DSS) day support staff #1. what the Individual had for						
lu th be	nch DSS staff verl e Individual had a	palized to the surveyor that roast beef sandwich that had at into 4 pieces (quartered),						
SL		SP DSS #1 verbalized to the ndwich was "probably not			RECEIVE			
wi		ndividuals diet was reviewed d senior team leader on nately 5:25 p.m.		· !	JUN 0 1 2015 VDH/OLC			

conference.

No further information regarding Individual #4's diet was provided to the surveyor prior to the exit

#### PRINTED: 05/21/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARE SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED 49G018 B. WING 05/06/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE POST OFFICE BOX 621 **BAXTER HOUSE** KEEN MOUNTAIN, VA 24624 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ΙD PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE OATE DEFICIENCY) 5118613 W 249 483.440(d)(1) PROGRAM IMPLEMENTATION W249 The QIDP will dontinue to regularly monitor each As soon as the interdisciplinary team has individuals meal time formulated a client's individual program plan, plan | diet to ensure staff each client must receive a continuous active are implementing correctly. treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff and day support staff failed to consistently implement the active treatment plans regarding nutrition for 2 of 4 Individuals, Individuals #3 and #4. The findings included.

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skills."

constipation.

1. For Individual #3, the group home staff failed to implement the Individuals goal to "Improve eating

Individual #3 was admitted to the facility 12/04/90. Diagnoses included but were not limited to, profound intellectual disabilities, intermittent explosive disorder, insomnia, and history of

Individual #3's record included the goal "Improve

Monday-Sunday 5:00-5:30 PM-Monday-Friday 7:00-7:30 AM- Saturday-Sunday 9:00 AM-9:30 AM." The Procedure for liquids read as follows "...Pour 1" (inch) of liquid in a glass at a time to slow his rate of drinking down. Rapid swallowing

eating skills." The lesson plan was to be implemented "7 days per week...2 times daily.

		AND HUMAN SERVICES & MEDICAL SERVICES			(	FORM	D: 05/21/2015 MAPPROV <b>E</b> D
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DA	). 0938-0391 TE SURVEY MPLETED
		49G018	B. WING	i		0.5	5/06/2015
NAME OF E	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		70072013
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W 249	Continued From pa	ge 5	۱۸/ ۱	249			२ १८८।
:	of liquids places hin aspiration"	-	** 2	_ 70			
	a.m. the surveyor of breakfast. Individual meal by RT (resider #3 was observed by coffee cup and take Individual #3 to slow again observed by the coffee from his coffee measured and drink glass without it beind during the breakfast measuring Individual	ing at approximately 7:00 oserved Individual #3 eating I #3 was assisted with this atial technician) #1. Individual the surveyor to pick up his a large drink. RT #1 asked to down. Individual #3 was the surveyor drinking his ee cup without it being sing his milk from a large g measured. At no time a meal was the staff observed al #3's liquids.					
	surveyor interviewed the surveyor that sh amount of liquids int	oximately 7:30 a.m. the drawn of RT #1. RT #1 verbalized to e usually poured a small to another cup but she did not do so this am.					
	on 05/06/15 at appro	der was notified of the above eximately 8:38 a.m. and the solified on 05/06/15 at a.m.					:
	No further information provided to the survice conference.	on regarding this issue was eyor prior to the exit					
		the day support staff failed to duals diet of "finely chopped		:			
	Individual #4 was ad	mitted to the facility 06/11/13.					

#### PRINTED: 05/21/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICA **SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 49G018 B. WING 05/06/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **POST OFFICE BOX 621 BAXTER HOUSE** KEEN MOUNTAIN, VA 24624 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2118515 W 249 Continued From page 6 W 249 Diagnoses included, but were not limited to, moderate intellectual disabilities, intermittent explosive disorder, seizure disorder, and hypothyroidism. The Individuals diet was documented on the face sheet as "finely chopped foods with thickened liquids." The face sheet had been updated 03/17/15. The 90 day renewal of orders, signed by the physician on 03/02/15, included the diet "Regular calorie, Finely chopped with thickened liquids." Individual #4's record included the goal "To maintain desired weight for height..." The lesson plan included the following steps "1. Provide regular calorie diet as tolerated...finely chopped Food diet with thickened liquids. 2. Encourage slowed eating and small bites to prevent choking. 3. Direct care staff will provide diet as ordered...' The annual nutrition assessment was completed on 07/07/14 "...current diet is Regular calorie finely chopped with thickened liquids..." Page 12 of 19 of the ISP (individual support plan) read in part "DSP (direct support professional) makes sure (name omitted) food is finely chopped (due to him not having any teeth)..." RECEIVED

On 05/05/15 beginning at approximately 11:15 a.m. the surveyor arrived at the day support

The surveyor observed the Individual eating lunch beginning at approximately 12:30 p.m. Individual #4 was served a lunch that consisted of a sandwich that had been cut in four parts, fruit

program that was attended by Individual #4.

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		AND HUMAN SERVICES  & MEDICAL SERVICES			(	FOR	D: 05/21/2015 M APPROVED O: 0938-0391
	F OF OEFICIENCIES DF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO		ONSTRUCTION	(X3) O	ATE SURVEY OMPLETEO
		49G018	B. WING			0	5/06/2015
NAME OF	PROVIOER OR SUPPLIER			STRE	ET AOORESS, CITY, STATE, ZIP CO		<u> </u>
BAXTER	HOUSE				T OFFICE BOX 621 IN MOUNTAIN, VA 24624		
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W 249	Continued From page 7 cocktail, salad, and thickened liquids. Individual #4 was observed to pick up his sandwich and was able to feed himself.  The Resident tolerated the diet without difficulty.  After this observation the surveyor reviewed the Individuals record.  On 05/05/15 at approximately 3:15 p.m. the surveyor interviewed (DSS) day support staff #1. DSS #1 was asked what the Individual had for lunch DSS staff verbalized to the surveyor that the Individual had a roast beef sandwich that had been toasted and cut into 4 pieces (quartered), fruit cocktail, and honey thick liquids.			249			5/28/15
		SP DSS #1 verbalized to the ndwich was "probably not	:	: : :			!
		ndividuals diet was reviewed d senior team leader on mately 5:25 p.m.	:	:			† :
		on regarding Individual #4's the surveyor prior to the exit	-  -  -  -  -  -  -	:			

W 368 483.460(k)(1) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

This STANDARD is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a

W 368 The Facility Manager spoke with the physician on S/21/15 in regards to individual #H not receiving his multivitamin For several days, due to his delay in sending the pharmacist the prescription for the refill He assured methis would not happen again and

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO:8QB0t1

Facility IO: VAICFMR02

If continuation sheet Page 8 of 10

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## DEPARTMENT OF HEALTH AND HUM?" SERVICES CENTERS FOR MEDICARE & MEDICA. SERVICES

PRINT**E**D: 05/21/2015 FORM APPROVED OMB NO 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G018	B. WING	3		05/0 <b>6/2</b> 01 <b>5</b>	
NAME OF PROVIDER OR SUPPLIER  BAXTER HOUSE				STREET ADDRESS, CITY, STATE, ZIP COI POST OFFICE BOX 621 KEEN MOUNTAIN, VA 24624	DE.		
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W 368	The findings included The physician order was not available for 05/01-05/05/15.  Individual #4 was as Diagnoses included moderate intellecture explosive disorder, hypothyroidism.  Individual #4's 90 day and signed by the purposite the publication of the multivitamin when reviewing May administration recording facility staff had place note across the administration recording the multivitamin for verbalized to the sur	nedication was available for of 4 Individuals, Individual #4.  ed.  red medication multivitamin or administration at the facility  dmitted to the facility 06/11/13.  I, but were not limited to, al disabilities, intermittent seizure disorder, and  ay renewal of orders dated hysician on 03/02/15 included nin 1 (po) by mouth 1 X ment." The original issue date was documented as 06/11/13.  by 2015 MAR's (medication reds) it was noted that the ced part of a yellow post it ninistration blocks for the ditranscribed on this post it t."  c) #3 was interviewed on mately 4:40 p.m. regarding Individual #4. RT #3 reyor that the multivitamin om the pharmacy and they	W	That prescriptions for medications wo sent in a timely min the fotore. The manager will continued this situation this situation at monthly basis, out refills are recipin a timely manner in a timely manner to a timely manne	nann Facili inve ation to en ceive	ier to on nsore	
		leader) was notified on ultivitamin was not available the facility.				:	

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Event ID:8QB011

Facility ID: VAICFMR02

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICA SERVICES

PRINTED: 05/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(	(X3) DATE SURVEY COMPLETED	
		49G018	B. WING			05/06/2015	
NAME OF PROVIDER OR SUPPLIER  BAXTER HOUSE				STREET ADDRESS, CITY, STATE, ZIP OF POST OFFICE BOX 621 KEEN MOUNTAIN, VA 24624	ODE	00.00.10	
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W 368	pharmacy was come Pharmacist #1 spol The pharmacist verwas unable to fill the have a prescription Pharmacist #1 state prescription for the be filling it. Pharma sometimes difficult physician.  A review of the MAI the facility staff had note and had transot tablets on 5-5-15." documented on the administered the m 05/06/15.  No further informati	roximately 5:50 p.m. the racted by the facility. The with the surveyor via phone. It is a considerable of the surveyor that he will be a multivitamin as he didn't to refill the medication. The detailed had received a multivitamin today and would count with the stated that it was to get refills from the current of the country of the current of the current of the stated that removed the yellow post it cribed on the MAR "Added 31. The facility staff had	W 3	;68		5 38 15	
:							
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Event ID:8QB011

Facility ID: VAICFMR02

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